Diabetes Services Order Form (DSMT and MNT Services)

*Indicates required information for Medicare order

PATIENT INFORMATION

Patient's Last Name _____ First Name _____ Middle _____

Date of Birth ____/____/____ Medicare HICN # _____ Gender ____ Male ____ Female

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Other Contact Phone _____

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. For Medicare beneficiaries, both services can be ordered in the same year. Research indicates MNT combined with DSMT improves outcomes.

DIABETES SELF-MANAGEMENT TRAINING (DSMT)

Medicare: 10 hours initial DSMT in 12-month period, plus 2 hours follow-up DSMT annually

**Check type of training services and number of hours requested:*

- ☐ Initial group DSMT: ☐ 10 hours or ____ no. hrs. requested
- ☐ Follow-up DSMT: ☐ 2 hours or ____ no. hrs. requested
- ☐ Additional insulin training: ____ no. hrs. requested

*** Patients with special needs requiring individual DSMT**

Check all special needs that apply:

- ☐ Vision ☐ Hearing ☐ Physical ☐ Cognitive Impairment
- ☐ Language Limitations ☐ Other _____

*** DSMT Content**

- ☐ All ten content areas, as appropriate
- ☐ Monitoring diabetes
- ☐ Psychological adjustment
- ☐ Nutritional management
- ☐ Medications
- ☐ Preconception/pregnancy management or gestational diabetes management
- ☐ Diabetes as disease process
- ☐ Physical activity
- ☐ Goal setting, problem solving
- ☐ Prevent, detect and treat acute complications
- ☐ Prevent, detect and treat chronic complications

* DIAGNOSIS

Please send recent labs for patient eligibility & outcomes monitoring

- ☐ Type 1 uncontrolled ☐ Type 1 controlled
- ☐ Type 2 uncontrolled ☐ Type 2 controlled
- ☐ Gestational diabetes ☐ Other _____

Complications/Comorbidities

Check all that apply:

- ☐ Hypertension ☐ Dyslipidemia ☐ Stroke
- ☐ Neuropathy ☐ Nephropathy ☐ PVD
- ☐ Renal disease ☐ Retinopathy ☐ CHD
- ☐ Non-healing wound ☐ Pregnancy ☐ Obesity
- ☐ Mental/affective disorder ☐ Other _____

MEDICAL NUTRITION THERAPY (MNT)

Medicare: 3 hours initial MNT in the first calendar year, plus two hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

** Check the type of MNT and/or number of additional hours requested:*

- ☐ Initial MNT ☐ Annual follow-up MNT
- ☐ Additional MNT services in the same calendar year, per RD recommendations ____ no. additional hrs. requested

Please specify change in medical condition, treatment and/or diagnosis:

CURRENT DIABETES MEDICATIONS

Specify type, dose and frequency

Oral:

Insulin:

Patient now uses: ☐ Pen ☐ Needle ☐ Pump

PATIENT BEHAVIOR GOALS/PLAN OF CARE

*Signature and UPIN # _____ *Date ____/____/____

Group/practice name, address and phone: _____

Revised 8/31/05 by the American Dietetic Association and the American Association of Diabetes Educators after substantial review and consultation. Authors do not recommend or endorse any revisions or modifications.